4 August 2007
Chemist+Druggist
The newsweekly for pharmacy
www.dotpharmacy.com

Paying the price of change

RPSGB raises fees by 50 per cent

Sanofi-aventis announces outcome of distribution review

- Facing up to the flood aftermath
- What can pharmacy learn from Tesco?

www.nicorette.co.uk

at times when breakthrough cravings occur, strike back with nicorette® Combination Therapy

nicotine

- 1 in 2 smokers using nicorette® Combination Therapy had successfully stopped smoking at 6 weeks[1]
- nicorette® Combination Therapy is up to 50% more effective than monotherapy at 12 weeks[1,2]
- For smokers who have used a single form of NRT before but need help to manage breakthrough cravings[3]

for every cigarette, there's a nicorette

Nicorette Patch Product Information: Presentation: Transdermal delivery system available in 3 sizes (30, 20 and 10cm²) releasing 15mg, 10mg and 5mg of nicotine respectively over 16 hours. **Uses:** Relief of nicotine withdrawal symptoms as an aid to smoking cessation. **Dosage: Adults (over 18 years):** Patients should stop smoking during treatment. The patch should be applied to the skin on the hip, upper arm or chest in the morning and removed at bedtime. Application should be limited to 16 hours per day. Initially one 15mg patch daily for 8 weeks. Dose should be reduced to 10mg for 2 weeks and then 5mg for a further 2 weeks. Adults who use NRT beyond 6 months should seek advice from a healthcare professional. **Adolescents (12 to 18 years):** As per adult, but duration of therapy should not exceed 12 weeks without consulting a healthcare professional. **Under 12 years:** Not recommended. **Contraindications:** Hypersensitivity. **Precautions:** If erythema may occur if severe or persistent, discontinue treatment. Unstable cardiovascular disease, recent myocardial infarction, severe arrhythmias, hyperthyroidism, phaeochromocytoma, generalised dermatological disorders, renal or hepatic impairment. Stopping smoking may alter the metabolism of certain drugs. Transferred dependence is rare and less harmful and easier to break than smoking dependence. May enhance the haemodynamic effects of, and pain response to, adenosine. Keep out of reach and sight of children and dispose of with care. **Pregnancy and lactation:** Only after consulting a healthcare professional. **Side effects:** Erythema, application site reactions, pruritus, headache, nausea, vomiting, GI discomfort, dizziness, palpitations, reversible atrial fibrillation. See SPC for further details. **NHS Cost:** 15mg patches packs of 7: £9.07, 10mg packs of 7: £9.07, 5mg packs of 7: £9.07. **Legal category:** GSL. **PL holder:** Pharmacia Limited, Ramsgate Road, Sandwich, Kent, CT13 9NJ. **PL numbers:** 0032/0292, 0293, 0294. **Date of preparation:** March 2007.

Nicorette Gum Product Information: Presentation: Nicorette 4mg gum and Nicorette 2mg gum contain 4mg and 2mg nicotine respectively in a chewing gum base. Original, Mint, Freshmint and Freshfruit flavours. **Uses:** Relief of nicotine withdrawal symptoms to aid in stopping smoking. Used to help smokers ready to stop smoking immediately and also smokers who need to abstain from smoking occasionally. **Dosage: Adults (over 18 years):** No more than 15 pieces of gum should be used each day. Maximum amount of nicotine obtained from smoking 20 or less a day should use 2mg gum. Those smoking more than 20 should use 4mg gum. Chewed slowly for about 30 minutes. *Smoking cessation:* Patients should stop smoking during treatment. After up to 3 months ad libitum dosage, Nicorette gum use should be gradually reduced. Those who use NRT beyond 9 months should consult a healthcare professional. *Smoking reduction:* Use the gum between smoking episodes to reduce smoking. A quit attempt should be made as soon as the smoker feels ready but no later than 6 months. Professional advice should be sought if no reduction in 6 weeks or no quit attempt in 9 months. **Adolescents (12 to 18 years):** No more than 15 pieces of gum should be used each day. Smoking cessation: After 8 weeks ad libitum dosage, reduce gum use over 4 weeks. If not stopped by 12 weeks, a healthcare professional should be consulted. *Smoking reduction:* Only after consulting a healthcare professional. **Under 12 years:** Not recommended. **Contraindications:** Hypersensitivity. **Precautions:** Denture wearers, GI disease, unstable cardiovascular disease, diabetes mellitus, uncontrolled hyperthyroidism, phaeochromocytoma, renal or hepatic impairment. Stopping smoking may alter the metabolism of certain drugs. Transferred dependence is rare and less harmful and easier to break than smoking dependence. May enhance the haemodynamic effects of, and pain response to, adenosine. Keep out of reach and sight of children and dispose of with care. **Pregnancy & lactation:** Only after consulting a healthcare professional. **Side effects:** Headache, sore mouth or throat, jaw-muscle ache, GI discomfort, hiccups, nausea, vomiting, dizziness, erythema, urticaria, palpitations, allergic reactions, reversible atrial fibrillation. See SPC for further details. **NHS Cost:** 2mg gum (10) £2.05, 2mg gum (30) £3.25, (105) £8.89, (210) £14.82; 4mg gum (30) £3.99, (105) £10.83, (210) £18.24. **Legal category:** GSL. **PL numbers:** Original 2mg 00032/0248, 4mg 0032/0249; Mint 2mg 0032/0250, 4mg 0032/0251, Freshmint 2mg 0032/0283, 4mg 0032/0295, Freshfruit 2mg 15513/0136, 4mg 15513/0137 **PL holder:** Pharmacia Ltd, Ramsgate Rd, Sandwich, Kent,CT13 9NJ. **Date of preparation:** March 2007. **References: 1.** Puska P, Korhonen HJ, Vartiainen E. et al. Combined use of nicotine patch and gum compared with gum alone in smoking cessation: a clinical trial in North Karelia. Tobacco Control. 1995;4:231-35. **2.** Kornitzer M, Boutsen M, Dramaix M, et al. Combined use of nicotine patch and gum in smoking cessation: a placebo-controlled clinical trial. Prev Med. 1995;24:41-47. **3.** Action on Smoking and Health. Guidance for Health Professionals on changes in the licensing arrangements for Nicotine Replacement Therapy. December 2005.

Date of preparation: June 2007

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recycle

Sanofi alters supply route

Third firm unveils plan to distribute its drugs via appointed wholesalers

Emma Wilkinson

Sanofi-aventis has become the latest drugs firm to appoint selected wholesalers to distribute its medicines to pharmacies.

From November 1 products will only be available through UniChem, Phoenix and AAH, echoing the deal announced by Napp Pharmaceuticals last week.

Keeping supply in the hands of the UK's three largest wholesalers will minimise disruption for pharmacists, sanofi-aventis claimed.

The drugs firm added that wholesalers will continue to set discounts under the arrangements.

Mike Isles, supply chain director at sanofi-aventis, said: "Under this new arrangement we can maintain the service levels that our customers enjoy today while improving supply chain efficiency in the delivery of our medicines to patients."

But critics hit out at the move. It will result in reduced choice for pharmacists, said Alison White, NPA chief executive. "There will be instances where our members will be forced to change the wholesaler they deal with. "The wholesalers not selected will have huge pressures on their margins – resulting in potential changes in volume discounts for NPA members."

She added: "With only three wholesalers available the flexible distribution model that pharmacy depends on will be undermined."

PSNC said it was working to minimise the impact of recent supply chain changes on pharmacies not currently with UniChem, Phoenix or AAH.

Martin Sawer, executive director of the BAPW, urged drugs companies to hold off on making changes to distribution until the OFT completed its investigation into supply of NHS medicines at the end of this year.

Sanofi products will only be available through UniChem, AAH and Phoenix from November 1

Pharmacists will face uncertainty

Pharmacists are set for financial uncertainty under the sanofi-aventis distribution changes, wholesalers excluded from the deal have warned.

John Davies, retail services director of wholesaler Mawdsleys, said: "There will be pharmacists who have long-term arrangements with other wholesalers – a number of whom are with Mawdsleys. They want to be able to make a choice and this is making them uneasy."

His sentiments were echoed by John Cochrane, managing director of Munro Wholesale, who said it was disappointing to lose this business without having the chance to make a case.

"To me this is more about profit and control," he said. "The independent regional wholesalers fulfil an important role in the marketplace in terms of competition, choice and service.

"There are not many instances where fewer suppliers mean lower prices for the customer. We are only seeing the first steps of a significant change process that will take place over the coming years." EW

Asda is customer experience winner

Asda has topped a chart comparing customers' experience of pharmacy services at supermarkets against Boots.

The assessment, carried out by customer experience management agency GAPbuster in conjunction with Checkout magazine, pitched the UK's four biggest supermarkets against Boots in five areas: speed of service, staff friendliness, staff interaction, till transaction, and staff and store presentation.

Asda recorded an overall score of 94 per cent – a lead of more than four points on closest rival Morrisons. Boots secured third place ahead of Tesco and Sainsbury's.

An Asda spokesperson said: "It's fantastic news that we've come top of this survey and is testament to the hard work our colleagues put in."

However, Boots expressed surprise at the results. "Boots prides itself on excellent customer service," a spokesperson said.

"That's why customers trust Boots." JR

Percentage of pharmacy customers satisfied by overall standard of service

Source: Checkout Aug 2007

News in brief

Napp clarification

C+D would like to clarify that Napp Pharmaceutical's distribution partnership with AAH, UniChem and Phoenix is not a 'direct to pharmacy deal' as described in our July 28 issue on p5. Napp plans to work within the traditional wholesale model and pharmacists will not need to open an account with Napp to order the company's products.

C+D online survey

Do your staff keep you sane or drive you mad? Could you work effectively as a pharmacist without them? C+D wants to get a better picture of the current staffing situation in community pharmacy. To take part in our online survey regarding pharmacy support staff visit www.dotpharmacy.com/staffsurvey

Pharmacy Update MCQs

The multiple choice questions for July's Pharmacy Update articles are enclosed with this week's issue of C+D. To enrol on the Pharmacy Update course, which is supported by Genus Pharmaceuticals, and contribute to your CPD portfolio, call Pauline Sanderson on 01732 377269. For more information visit www.dotpharmacy.com/up2007.html

CPW chief exec to retire

Peter Haydn Jones will retire from his post as Community Pharmacy Wales chief executive on September 1. "I leave the organisation confident that it is fit for purpose to drive the community pharmacy agenda forward in Wales," he said.

Lloyds EPS go-ahead

Lloydspharmacy has been granted authority to roll out EPS after a successful initial implementation, enabling electronic prescriptions to be generated, transmitted and received across its stores.

Medals announced

Dr Mary Tully, University of Manchester, is the winner of the C+D Practice Research Award Medal for her work on the process and outcomes of prescribing in secondary care. She will be presented with the award at the British Pharmaceutical Conference in September, along with Dr Molly Stevens, Imperial College, London, who receives the Conference Science Medal in recognition of her work in regenerative medicine, nanotechnology and tissue transplantation.

RPSGB retention fees increase by 50 per cent

Jennifer Richardson

The Royal Pharmaceutical Society has announced a practising retention fee of £425 for 2008 – an increase of 50 per cent on this year's £283 charge.

As the corresponding fees for non-practising and overseas pharmacists, as well as technicians, each went up by a similar proportion, the RPSGB blamed factors beyond its control for the rise.

These external pressures included increased costs of regulation arising from the Pharmacists and Pharmacy Technicians Act 2007 (Section 60 Order), deficits in the Society's pension scheme and the cost of creating the new regulatory body and royal college. The current inflation rate of 2.4 per cent accounts for less than £7 of the additional £142.

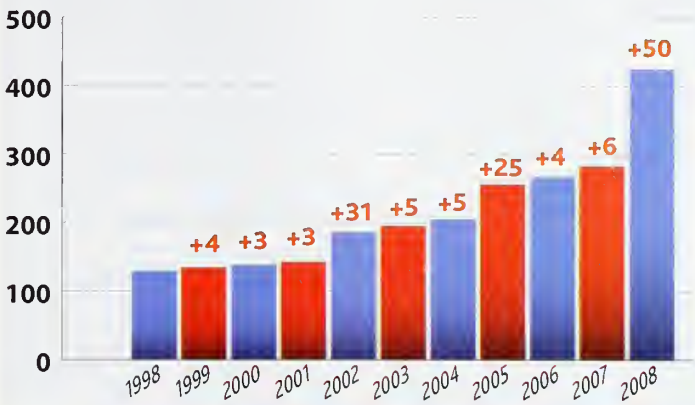
RPSGB treasurer Andrew Gush said: "This was not an easy decision for Council to make but the reality is that in 2008 we face major financial pressures that are out of our control."

As a result of the increase, the Society's income from the retention fees of nearly 40,000 practising pharmacists stands to total around £16m in 2008 – over £5m more than its approximate collection this year.

Society president Hemant Patel said he was determined the Society's members would see clear benefits from the money. "We very much want to continue to support branches, regions and the BPSA [British Pharmaceutical Students' Association]," he said.

"Going forward there will be additional financial resources for practice, education and communications activities."

Percentage increase in the RPSGB practising retention fee



Source: RPSGB

Angry reaction to increase

Some pharmacists have threatened to quit the profession in protest at the Royal Pharmaceutical Society's "outrageous" retention fees rise.

Internet forums including Locum Voice carried threats of fee boycotts and wishes to leave the profession rather than pay the £425 rate.

An online petition demanding that the RPSGB reconsider the increase had more than 3,500 signatures as C+D went to press.

You can view the online petition, 'Pharmacists against 50 per cent increase in retention fees', at www.gopetition.com/online/13615.html.

"I think it's outrageous. I find it difficult to justify that sort of increase."
Peter Smith, Morton Pharmacy, Carlisle

"It's barely worth the money as it is. We don't see where the money goes."
Dan Sandhu, Dean and Smedley, Mackworth

"I'm having to pay as much as someone who works full time, and that's a hell of an increase. I'm not happy."
Part-time locum Jenny Cox

RPSGB president 'understands' pharmacists' anger at fees hike

"I can fully understand why pharmacists would be angry," RPSGB president Hemant Patel said in response to fierce criticism of Lambeth's decision to increase the retention fees by 50 per cent in 2008.

Mr Patel said he shared members' frustration, but the government had left the Society with no choice. "I am angry we are having to ask members for more money, but at the same time I'm fully appreciative of why. We've been placed in a position where government is imposing things on us."

Fee rises will fund regulatory changes and implementing the Section 60 Order in line with DH demands, Mr Patel said. However, some of the extra £5m generated will also combat the RPSGB's pension deficit, the president revealed.

"There are many other organisations in the UK suffering difficulties with pension funds," Mr Patel said.

The RPSGB's Council had done what was necessary to ensure Lambeth's future financial viability, he said. "The most popular thing Council could have done is not to increase fees. But it would be irresponsible to use up our reserves and leave future councils with nothing." **MG**

What it will cost you in 2008 (2007 figures in brackets)

- Pharmacist registration £206 (£137)
- Pharmacist retention fee practising £425 (£283)
- Pharmacist retention fee non-practising £96 (£64)
- Technician retention fee practising £140 (£93)

Could the Society have covered costs any other way?

Sell Lambeth High Street headquarters and move to a cheaper location?

"The building in London does cost more money than having it in Manchester or Scotland. But we are having weekly meetings with the DH so any move would trigger additional travel expenses."
Hemant Patel

Staff redundancies?

"There will be a critical examination of every budget. Every director has been asked to justify their resources and by October we will have a much clearer picture about potential costs."
Hemant Patel

How pharmacy compares:

- GMC £290
- Nursing Midwifery Council £76
- General Dental Council £420
- General Optical Council £169

What do you think of the fee rise?
haveyoursay@cmpmedica.com

For more on practice-based commissioning:
www.dotpharmacy.com/PBC

PBC week
September 24-28

Submitting a formal, written service proposal to practice-based commissioners is not the first, nor even nearly the first, step to pitching to supply services under PBC.

A step-by-step guide to PBC

STEP 2

Generate ideas for a PBC service

Stephen Fishwick, head of NHS services development, NPA

Take account of the stage at which you are entering the local NHS commissioning cycle. If the PCT and practice-based commissioners have already agreed overarching annual plans for service redesign, your scope for invention may be limited.

In this case, the practice(s) PBC plans will give you the parameters for considering what services to develop at locality level.

If not, your PCT's local delivery plan is likely to be your primary source of information about targets and associated service opportunities. You can scope public health opportunities at locality (PBC) level by examining neighbourhood data (www.communityhealthprofiles.info), and even break down to practice level via PBC Comparators data, which shows activity and referral patterns and outcomes for a number of key conditions by GP practice. (Currently, you will only be able to access this information via a GP or the PCT.)

Equipped with such data, consider:

- What existing services provided in the local hospital or GP practice could be delivered from a pharmacy?
- What new services could be developed that would reduce the reliance on expensive specialist/hospital-based care?
- What else could you do to achieve cost-effective medicines use, or prevent illness and the associated costs of care?
- What would play to the unique strengths of community pharmacy – a combination of medicines expertise and unrivalled accessibility?

Next time: Step 3 – detailed research

PSNC chief calls for four extra advanced services

Sue Sharpe delivers wish list for the government ahead of autumn white paper

Max Gosney

PSNC chief Sue Sharpe has called for four more services to move to the advanced tier of the pharmacy contract.

Ms Sharpe urged the government to support smoking cessation, sexual health, obesity and weight management and basic diagnostic testing with national funding in this autumn's white paper on pharmacy services.

Talking exclusively to C+D, Ms Sharpe said: "What I would like in the white paper is for the government to use pharmacy sensibly.

"If Gordon Brown or Alan Johnson are serious about using pharmacy services then start telling patients a pharmacist can help them. Then you start to make primary care work."

Mr Brown said he wanted to see pharmacies taking on more work from GPs prior to becoming Prime Minister in June.

Pharmacists have proved through medicines use reviews that they are ready to take on extra healthcare duties, Ms Sharpe said. However, funding needs to be fixed before contractors commit to a broader primary care role, she added.

"Pharmacy has proved through advanced services what it can do. Meanwhile enhanced services have suffered because of all the changes at PCT level. It will only work if the public know they can go into any pharmacy and get these services."

Funding announcement

The contract funding package for 2007/08 is set to be announced this September.

The final agreement is unlikely to see an increase in the MUR limit from 400. But pharmacists could see a small increase in the £25 fee they are currently paid per MUR, C+D understands.

Sue Sharpe: "Start telling patients a pharmacist can help them"

Should more services be nationally funded?
mgosney@cmpmedica.com

The chair of the all-party pharmacy group has urged pharmacists to send their local MPs a postcard in protest at plans to make pseudoephedrine and ephedrine prescription-only. Thirty-five MPs have signed all-party pharmacy group chair Howard Stoate's early day motion proposing a Commons debate on POM switch proposals. But Dr Stoate is aiming for 100 signatures before parliament reconvenes in October – and needs your help. "Postcard campaigns can be amazingly successful. Once you get into triple figures ministers realise how important the issue is." Go to www.upmystreet.com/commons/l/ to find your local MP

Chlamydia screening not cost-effective

Proactive chlamydia screening for the young would be an expensive intervention and not value for money, a group of health economists at the University of Birmingham has said.

Most previous studies have advocated proactive screening, and some GP practices are sending out patient re-screening reminders.

However, from mathematically modelling the effect of proactive screening, the Birmingham group found the incremental cost ratio per major outcome averted after eight years would be £28,900. Writing in the BMJ, it suggested that this was not good value for money. **GMA**

Doncaster cracks down on script fraud

A campaign by Doncaster PCT to catch out individuals wrongly claiming free prescriptions on the NHS is capturing 100 people a month.

Carrying out random spot checks of a few pharmacies a month is proving so successful the PCT has turned to the help of a debt collection service to round up the fines, which can be up to £100.

Mark Bishop, counter fraud specialist at the PCT, said they had found one man who had tried to claim a free prescription nine times in a row when he was not entitled.

"We check the details and if it's not backed up we write to the patients to ask them to prove they are exempt."

He said 60–70 per cent of patients they wrote to were claiming free prescriptions they weren't entitled to.

An NHS Counter Fraud Service spokesman said that since 1999, prescription fraud has been cut by 60 per cent to £47 million.

"Unfortunately, there is still too much money being lost. Patients claiming free prescriptions without entitlement are not only breaking the law, but deprive the NHS of millions of pounds," he said. **EW**

NEW IN SMOKING CESSATION

THE POWER TO HELP THEM QUIT.[1-3]

- **A new class of oral prescription therapy with a unique dual action:**[1,2,4]
  - **Partial agonist** action: Reduces craving and withdrawal symptoms†
  - **Antagonist** action: Reduces the satisfaction associated with smoking†
- **Significantly higher quit rate vs. bupropion or placebo at 12 weeks**[1,2,5]
- **Favourable safety and tolerability profile in approximately 4,000 treated smokers**[6]

†Based on the Minnesota Nicotine Withdrawal Scale (MNWS)

CHAMPIX® Film-Coated Tablets (varenicline tartrate) ABBREVIATED PRESCRIBING INFORMATION - UK. Please refer to the SmPC before prescribing Champix 0.5 mg and 1 mg. **Presentation:** White, capsular-shaped, biconvex tablets debossed with "*Pfizer*" on one side and "CHX 0.5" on the other side and light blue, capsular-shaped, biconvex tablets debossed with "*Pfizer*" on one side and "CHX 1.0" on the other side. **Indications:** Champix is indicated for smoking cessation in adults. **Dosage:** The recommended dose is 1 mg varenicline twice daily following a 1-week titration as follows: Days 1-3: 0.5 mg once daily, Days 4-7: 0.5 mg twice daily and Day 8-End of treatment: 1 mg twice daily. The patient should set a date to stop smoking. Dosing should start 1-2 weeks before this date. Patients who cannot tolerate adverse effects may have the dose lowered temporarily or permanently to 0.5 mg twice daily. Patients should be treated with Champix for 12 weeks. For patients who have successfully stopped smoking at the end of 12 weeks, an additional course of 12 weeks treatment at 1 mg twice daily may be considered. Following the end of treatment, dose tapering may be considered in patients with a high risk of relapse. **Patients with renal insufficiency:** *Mild to moderate renal impairment*: No dosage adjustment is necessary. *Patients with moderate renal impairment who experience intolerable adverse events*: Dosing may be reduced to 1 mg once daily. *Severe renal impairment*: 1 mg once daily is recommended. Dosing should begin at 0.5 mg once daily for the first 3 days then increased to 1 mg once daily. *Patients with end stage renal disease*: Treatment is not recommended. **Patients with hepatic impairment and elderly patients:** No dosage adjustment is necessary. **Paediatric patients:** Not recommended in patients below the age of 18 years. **Contraindications:** Hypersensitivity to the active substance or to any of the excipients. **Warnings and precautions:** Effect of smoking cessation: Stopping smoking may alter the pharmacokinetics or pharmacodynamics of some medicinal products, for which dosage adjustment may be necessary (examples include theophylline, warfarin and insulin). Smoking cessation may result in an increase of plasma levels of CYP1A2 substrates. Smoking cessation, with or without pharmacotherapy, has been associated with the exacerbation of underlying psychiatric illness (e.g. depression). There is no clinical experience with Champix in patients with epilepsy. At the end of treatment, discontinuation of Champix was associated with an increase in irritability, urge to smoke, depression, and/or insomnia in up to 3% of patients, therefore dose tapering may be considered. **Pregnancy and lactation:** Champix should not be used during pregnancy. It is unknown whether varenicline is excreted in human breast milk. Champix should only be prescribed to breast feeding mothers when the benefit outweighs the risk. **Driving and operating machinery:** Champix may have minor or moderate influence on the ability to drive and use machines. Champix may cause dizziness and somnolence and therefore may influence the ability to drive and use machines. **Side effects:** Adverse reactions during clinical trials were usually mild to moderate. Most commonly reported side effects were abnormal dreams, insomnia, headache and nausea. Commonly reported side effects were increased appetite, somnolence, dizziness, dysgeusis, vomiting, constipation, diarrhoea, abdominal distension, stomach discomfort, dyspepsia, flatulence dry mouth and fatigue. See SmPC for less commonly reported side effects. **Overdose:** Standard supportive measures to be adopted as required. Varenicline has been shown to be dialyzed in patients with end stage renal disease, however, there is no experience in dialysis following overdose. **Legal category:** POM. **Basic NHS cost:** Pack of 25 11 x 0.5 mg and 14 x 1 mg tablets Card (EU/1/06/360/003) £27.30, Pack of 28 1 mg tablets Card (EU/1/06/360/004) £27.30, Pack of 56 0.5 mg tablets HDPE Bottle (EU/1/06/360/001) £54.60, Pack of 56 1 mg tablets HDPE Bottle (EU/1/06/360/002) £54.60, Pack of 56 1 mg tablets Card (EU/1/06/360/005) £54.60. Not all pack sizes may be marketed / marketed at launch. **Marketing Authorisation Holder:** Pfizer Limited, Sandwich, Kent, CT13 9NJ, United Kingdom. **Further information on request:** Pfizer Limited, Walton Oaks, Dorking Road, Tadworth, Surrey KT20 7NS. Last revised: 09/2006

Adverse events should be reported to Pfizer Medical Information on 01304 616161. Information about adverse event reporting can also be found at www.yellowcard.gov.uk

References: 1. Gonzales D *et al.* JAMA 2006; 296:47-55. **2.** Jorenby DE *et al.* JAMA 2006; 296:56-63. 3. Tonstad S *et al.* JAMA 2006; 296:64-71. **4.** Coe JW. J Med Chem 2005; 48:3474-3477. **5.** Gonzales DH *et al.* Presented at 12th SRNT, 15-18th Feb, 2006, Orlando, Florida. Abstract PA9-2. 6. CHAMPIX Summary of Product Characteristics.

CHA055a Date of preparation: Nov 2006

Pfizer

New oral prescription medicine

CHAMPIX

varenicline tartrate

News in brief

Green computer disposal

Pharmacies upgrading their computer systems should consider how they safely dispose of the old machines without harming the environment, according to Cegedim Rx. The company is offering to collect out of date computers, delete confidential information and pass the equipment on for recycling.

e-learning launch

The Centre for Pharmacy Postgraduate Education has set up an e-learning programme in pharmacogenetics. It is the first of a series of interactive courses designed to aid learning through online activities and tests.

Galbraith delay welcome

The RPSGB and Pharmacy Practice Research Trust have welcomed the Department of Health's announcement that the Galbraith review will be postponed until the autumn. The delay, brought about to wait for an upcoming white paper on pharmacy services, will allow the Department to take a more holistic overview, the bodies said.

NHS service interest high

NPA Brief Guides on service developments are proving popular, suggesting pharmacists are keen to explore new NHS services, despite frustrations around funding. Around 1,500 copies have been ordered, with diabetes, asthma/COPD, CHD/hypertension, anticoagulation and obesity in particular demand, the NPA said.

Help for drug misusers

Nice guidelines issued this week specify that where concerns about drug misuse are identified the patient should be offered two non-judgemental motivational sessions. Patients who misuse drugs should also be routinely given information about self-help groups. www.nice.org.uk

Therapy good on its own

Antiplatelet therapy is as effective on its own in preventing MI, stroke or death from cardiovascular causes as when used in combination with oral anticoagulants, a study has revealed. Results from the study published by the New England Journal of Medicine also showed that combination therapy increases the risk of life-threatening bleeds.

Don't remain silent on remote supervision

Pharmacists' Defence Association points to 'largely unnoticed' legislation

Jennifer Richardson

Pharmacists must speak out on rule changes that could allow support staff to dispense medicines in their absence, an industry representative has warned.

Legislation allowing the introduction of remote supervision has gone largely unnoticed by the profession, warned John Murphy, director of the Pharmacists' Defence Association.

He said: "The Health Act [2006] slipped through without people realising the full implications.

"Pharmacists ought to realise that they have an opportunity for their views to shape these regulations."

The comments come ahead of a Department of Health consultation on the health act later this year.

The government claims rules should be relaxed to allow one pharmacist to be responsible for multiple premises.

However, the PDA says such changes could compromise patient safety and reduce public access to pharmacists.

No changes to supervision rules have yet been made. But the Health Act gives the secretary of state for health the power to enable proposed changes in the future.

Representative bodies urged grass-roots feedback on the relaxation of supervision rules. PSNC's head of regulation Steve Lutener said LPCs should look to raise awareness among pharmacists so they could contribute to the consultation.

Your views on remote supervision

"If I'm off the premises, I wouldn't be able to feel responsible for what happens on the premises."
Tony Pawasker, United Norwest Co-operative Healthcare, Stalybridge, Cheshire

"I think remote supervision is being pushed through by the big companies so they can run their 100-hour pharmacies. It's a financial move and I think it will be something that the public will actually rue. What's the point of having a community pharmacy without having a pharmacist in it? You can't check an item over the phone or a TV screen, can you?"
David Sharp, D&R Sharp Chemists Ltd, Doncaster

"With the staff I've got I wouldn't have a problem [with remote supervision] but I've worked in other premises where I think it would be risky."
Ian Dunphy, Ten O' Clock Chemist, Oxford

Original image ARX

What do you think about remote supervision?
haveyoursay@cmpmedica.com

A cricket fan is given free sunscreen provided by Lloydspharmacy at a NatWest One Day International Series match. Lloyds and NatWest have teamed up with Marie Curie Cancer Care for the sixth year to run the 'Sun Safety – Don't Get Caught Out' campaign, which has raised over £400,000 for the charity's skin cancer research. England cricketer Paul Collingwood said: "Being outside for long periods of time means I have to be sun safe – it's so important not to get caught out"

Reprimand for false declaration

A Leeds pharmacist has been reprimanded for failing to declare previous convictions against him and his company.

Peter Freeman failed to inform local health trusts of incidents related to the sale of items without a prescription, the disciplinary hearing heard.

Statutory committee chairman, Lord Fraser of Carmyllie QC, said: "We don't want to see him again," adding: "It was a serious error."

Mr Freeman was fined £100 and £1,000 with £4,000 costs over the incidents at separate hearings at Leeds Magistrates Court.

However, the convictions were excluded in his Fitness to Practice declarations.

Mr Freeman's duty to disclose the convictions came under professional regulations, Lord Fraser stressed.

RPSGB official Geoff Hudson said Mr Freeman, of 14 Gateland Drive, had completed the forms "too quickly and didn't intend to mislead". **UKL**

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Pharmacy Champions

Out of hours

When I'm not at work, I like to go to the gym and to play racquet sports

Under the white coat

If I was in charge of pharmacy for just one day, I would scrap annual fees and give pharmacists more freedom to change things on prescriptions

Shirley Cox – of Assura Pharmacy, West Everton, Liverpool – has set up a mini-health check service

We have set up a free mini-health check.
This involves diabetes screening, cholesterol screening and blood pressure monitoring. This links in turn to MURs and weight management services. The mini-health check is quite flexible in that patients can decide what they would like done, be it all three tests or just individual tests.

There has been a great response to the service.
We were recently invited to do a stand in a local community centre along with a number of other healthcare agencies; we were inundated with requests to do mini-health checks. It was so successful we have been invited to run another one at another local centre. And, of course, we have the backing of Assura, who are such a forward-thinking company.

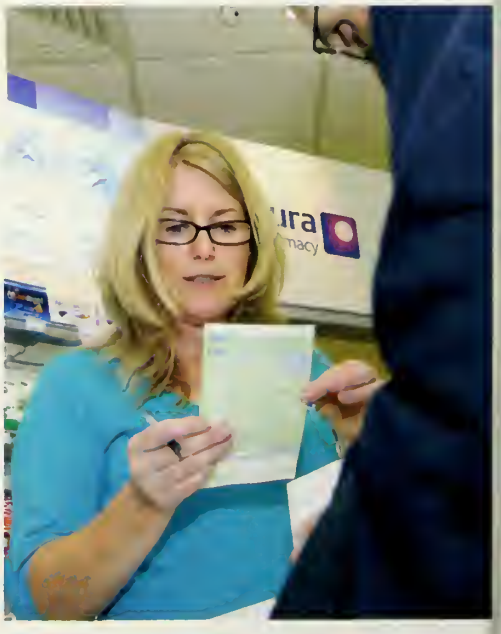
Our GPs are aware we offer these services.
I think they were just worried they would not receive any information concerning their patients. However, we have forms that are sent on to the [illegible] of this.

The positive outcome of this service.
Patients are beginning to acknowledge that there is more to their local pharmacy than just handing out medicines. It has also taken Assura Pharmacy out into the community.

But...
There is a lot of training involved, not to mention a lot of paperwork!

If anyone is planning to set up such a service.
Make sure all the necessary guidelines and SOPs are in place. It's essential that staff are trained and are confident, and know when to refer. Be available to patients and strive to go that extra mile.

Offering the new service has improved my job satisfaction.
It's great to get the message across that your local pharmacy can offer so much more than just dispensing medicines, and that we are part of the community.



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Reference: 1. MIMS, June 2007.

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Date of preparation: June 2007

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Your letters

Pharmacist errors – the electronic safety net

Mark Koziol's comments (C+D, July 28, p14) concerning the RPSGB inspectorate's position on the use of error logs and the classification by the FtP directorate that what would normally be considered to be one dispensing error is being classified as two is extremely alarming.

Pharmacists are working within an increasingly hostile regulatory regime, and are rapidly discovering that it is not only patients whose safety is put at risk by dispensing or supervisory errors, but their own professional survival.

Urging greater and greater vigilance is all very well but unfortunately human error is an absolute certainty. So after pharmacists and dispensing technicians, where does the next line of defence lie? As in most activities, whether it's computers in pharmacies or robots building cars, technology will consistently do whatever it is programmed to do without distractions, boredom or emotional troughs affecting performance.

Barcode reading has been around in pharmacy systems for a while and so has robotic dispensing, but a number of powerful new linkages are being developed by system suppliers which reduce the chances of error at every stage of the dispensing process. This is how it works:

- A prescription arrives either electronically or manually and the real or virtual barcode is checked into the pharmacy computer system.
- The dispensary computer automatically orders a robot to dispense the product or it is dispensed manually.

The robot or dispenser picks the product which is then labelled with a uniquely barcoded patient label.

A final three-way check of barcodes on patient label, product and prescription ensures complete accuracy.

This powerful consolidation of information at the final check, backed up by a full audit trail, takes clinical governance to new levels and turns error detection from a game of chance to a precise science. The end result: patient safety is improved and the pharmacist's record remains unblemished.

Martin Jones
commercial manager
Positive Solutions

Locum at large should blame the system...

I am writing in response to the "locum at large" article (C+D, July 28, p12). It is true that the majority of pharmacies perform little/no MURs at present. In a previous role as a regional manager I have seen, first hand, that this is the case.

I am now a branch pharmacist and, having completed many MURs in the past, I am finding it increasingly difficult to complete the target set by my employer.

The locum seems to suggest that there is a lack of desire, will, or even care, by employee pharmacists to complete MURs. In my experience this is most definitely not the case. As an employee it is becoming increasingly difficult to balance the expectations of the employer (increased profit, reduction in overtime, reduced wage bill, increased prescription numbers) and the opportunities offered in the new contract. The MUR is an ideal opportunity to formalise, and receive remuneration for, a service which many pharmacists perform on a routine basis with almost every prescription throughout the day. Sadly, employers do not seem to realise that taking the additional time required to perform an MUR, and increase prescription numbers by up to 10 per cent per annum, is simply not possible. I would ask the locum why they have not [illegible] MURs off their own back [illegible] they have worked in? Is it due to a lack of resources, time, or desire by the owner of the business?

> "Taking the additional time required to perform an MUR, and increase prescription numbers by up to 10 per cent, is simply not possible"

The "centres of excellence" referred to in the article are those that have embraced the new contract with the verve that it deserves; increased staffing, investment in a new store layout (rather than simply retro-fitting a 'resonance box' into each branch irrespective of whether there is space to accommodate such a monstrosity), appropriate training for staff and incentives to return the desired numbers (eg Day Lewis's £10k lottery). It appears that most employers have not adapted to the new contract in this way. The big three (Lloyds, Boots and the Co-op's) seem to have simply placed consultation areas into branches and set each branch a target without the requisite support.

Pharmacy, as a whole, needs to adapt. Much blame has been laid at the feet of the humble individual pharmacist but, I would argue, the failure to deliver the new service lies squarely at the door of the corporations: pharmacists simply cannot add in an additional, time-consuming, task without increased staff awareness or numbers of facilities. How can you expect your pharmacist to ignore the 12 people waiting in your shop to spend 20 minutes with one person? Invest in new ACTs, additional pharmacists (we are told that the numbers are up, that locums are struggling for work, employ them!) and pay the pharmacist accordingly. Which other profession would agree to take on an additional task without any financial incentive?

My fear is that the damage is already done. Pharmacy had a chance to adapt to a new service, to change and to evolve. What did we do? Sat back, stayed still and attempted to transform into a new entity without changing our infrastructure. Sadly, I assume that the lack of investment and adaption by our own paymasters will, in the corridors of power, have been seen as a lack of desire to change, as us being content with our current lot, leading to us becoming foremen of "prescription factories" in the near future.

Ian Jenkins
community pharmacist
Neath, South Wales

... or perhaps not

I endorse 100 per cent the views expressed by your locum in C+D (July 28, p12). I find that this view is unanimous amongst my colleagues who are either waiting to retire or moving to another profession.

In the past four months seven of my colleagues (all under 50) have sold their pharmacy businesses citing "unrealistic and unachievable demands" from the pharmacy contract as the main reason for quitting.

Kiran Patel
Medigreen Chemist, by email

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Comment from the editor

The Society is to be congratulated this week for making a connection with the silent majority of its membership. Only last week Xrayser was saying pharmacists weren't vocal enough, yet now the profession is shouting from the rooftops.

The vocal expressions of horror at the announcement of a retention fee increase from £283 to £425 are everywhere.

The online pharmacist community has gone into overdrive. The fee has become the subject of blogs and forum postings and an online petition that had generated more than 3,500 signatures in two days when C+D went to press.

But this isn't an online minority – it is the RPSGB membership in uproar and it proves that pharmacists will vocalise their feelings when pushed hard enough.

The main criticism from pharmacists is that they just can't see what they are getting for their money. How can the raise be justified? What exactly is the Society spending the extra money on? Where is the business case, the budget? Had it not been made clear to the government that the Society should not foot the bill for setting up the General Pharmaceutical Council?

The pension deficit has already received nearly £2m in the form of an exceptional payment, which was agreed by Council in December last year. So what's going on?

Ultimately, pharmacists have to stump up the cash or leave the profession.

In the current climate, where the Society should be doing its utmost to win pharmacists' hearts and minds for the day when it might have to attract members to join its successor voluntarily, it's not winning anyone over.

This is a PR disaster – one which could have been anticipated, and perhaps mitigated to some extent, with a sensible explanation of why such an astronomical increase is necessary. **Fiona Salvage, deputy editor**

> "This is the RPSGB membership in uproar and it proves pharmacists will vocalise their feelings when pushed"

Your views

Public health – have you got it yet?

Good healthcare is all to do with the right drug to the right patient at the right time: harder than it sounds

Last year, shortly after I had been invited to be a fellow of the Faculty of Public Health I was waxing lyrical about "public health" and how important pharmacy was to an "old" pharmacy friend (that is a friend of many years) when he said: "I understand the whole stop smoking thing and trying to prevent addicts from harming themselves by providing them with needles and syringes and providing advice on healthy lifestyles, but what I really don't understand is how dispensing medicines has anything to do with public health?"

This stopped me short. For a long time I have taken for granted why medicines management is a public health issue and while I have dedicated time to trying to enlighten my public health colleagues. I just haven't stopped to find out whether members of my own profession understand this. So I tried to explain – starting with what public health aims to do..

The aim of public health practice is to maintain and improve the health of the population and in

recent years access to good clinical practice (including the appropriate use of medicines) has increasingly been recognised as an important factor in ensuring that patients achieve good health. In other words to achieve the aim of a healthy population the right patient needs to receive the right treatment in the right way at the right time. Consequently, public health practice has focused on influencing the quality of healthcare people receive.[1]

It has long been recognised that the use of medicines is the most common form of medical intervention in the UK, so the effective use of medicines must be central not only to the patient experience but also to the quality of healthcare. However, various studies have found that up to 50 per cent of medicines are not taken as prescribed[2] and adverse reactions to medicines are implicated in 5–17 per cent of hospital admissions.[3] Non-concordance of prescribed medicine can prevent full benefit from being obtained and cause unnecessary ill-health, premature death and significant avoidable cost to the NHS.[2,4]

As pharmacists we know that many problems with medicines can be prevented by monitoring the effects of long-term drug therapy, by identifying those at risk, and by modifying their medication where necessary.[5] In a nutshell – if you don't get all of the elements of medicines management right for an individual then they will end up with a poor health outcome which in itself is a public health problem!

So as far as I am concerned dispensing the right medicine to the right patient, in the right way at the right time is a pivotal role in public health. This makes a pharmacist's role central to good public health. I think he got it...

References:
1. Hicks in Griffiths and Hunter 1999 Perspectives in Public Health (p223-234) Oxford: Radcliffe Medical Press
2. From Compliance to Concordance, 1997, Royal Pharmaceutical Society of Great Britain, London.
3. Medicines and Older People (supplement to the NSF for Older People) 2001, Department of Health, London
4. Medicines for older people, Royal College of Physicians, J R Coll Physicians London 1997; 31:254-7
5. Prescribing for the older person, MeRec Bulletin 2000, 11:10.

Fiona Harris is a trustee director at PharmacyHealthLink

Xrayser

To err is human, but not if you're a pharmacist

I've always been reluctant to record my dispensing errors because I've always worked hard to make sure that I'm not hauled before the Statutory Committee. Highlighting all my errors in a log makes me feel vulnerable.

It's not that I'm trying to hide anything. I make errors the same as any other human being but, touch wood, nobody has ever come to any harm and I always deal with the patient in a sensitive and professional manner. The matter is always resolved to the satisfaction of myself and the patient.

But now that the Society's recent Law and Ethics Bulletin has made it a more serious offence not to keep an error log than it is to make an error in the first place I appear to have little choice. I do so want to get to the end of my career without ever appearing before the Committee.

I've been recording every error secure in the knowledge that all my colleagues are also doing so and that my errors are probably no worse than theirs. We can't all be struck off, can we?

Mark Koziol from the Pharmacists' Defence Association remains convinced that pharmacists are over-regulated and that they get a hard time from the Society. Most pharmacists would agree, and it's for this reason that my heart is often in my mouth when dealing with controlled drugs or any other possibly contentious legal issue.

Council member Graham Phillips has suggested that this frightened and over-cautious attitude does not encourage cutting edge practice. Why try anything novel when your professional body is as likely to strike you off as support you in your endeavours?

Even the Society's attempt to encourage better practice has apparently backfired, according to Mr Koziol (C+D, July 28, p14). We should be delighted that one dispensing error does not necessarily constitute a disciplinary episode, but somehow an error that reaches a patient counts as two rather than one. It sounds like I'm only safe if I can commit half an error.

Now I'm not sure if I'm I better off committing half a dispensing error, or the whole error of not recording my half an error. This is plainly ridiculous. I feel more insecure than ever. The case for joining the PDA has never been stronger as they seem one of the very few bodies willing to stick their neck out to support my best interests.

Where have all the good times gone?

An old patient popped in last week and I enjoyed catching up with news about him and his family. This brief chat put me behind in my work and brought disapproving looks from waiting patients but it was worth it. This reminded me that simply chatting to favourite customers used to be one of the best parts of the day for me. And it saddens me that I struggle to find the time or the energy for it any more.

I seldom chat to a patient now unless it's about their prescription or a health query. Apart from MURs I now only talk to patients if they specifically ask for me. My counter staff do most of the talking and consequently know most customers better than I do. I'm too busy dispensing and doing paperwork to even talk to my patients. No wonder robots are becoming more popular – I might as well be one.

Northern Ireland Notebook

Decision PSNI

At its recent extraordinary general meeting (EGM) to consider the changes being applied to professional regulation across the UK, PSNI presented six options it views as possible ways forward.

Only two are really practical and only one will ensure the long-term survival of PSNI which, I assume, is the main objective of our Council. Given the Council's lack of passion on this matter I might be wrong.

What is a shame, and where I agree with Council, is the complete lack of interest from ordinary members. The low turn-out at the EGM reflects a general lack of interest in what is a seismic change with significant implications for the future. Perhaps, as one delegate at the EGM suggested, the profession has lost confidence in PSNI, which if true can only hasten its demise.

What surprises me is that PSNI offered us its options but did not suggest which one Council might choose. It was almost as if president Raymond Anderson had not got that far in his thinking, which is strange given that three of the options will lead to PSNI's death and one – the status quo – is not an option at all.

> "There are only two options on the menu"

So there are only two options on the menu: a UK solution where PSNI ceases to exist and regulation is undertaken by a General Pharmaceutical Council, or a Northern Ireland solution where PSNI builds robust Chinese walls between regulation and professional development and leadership.

The other options are impractical. Where PSNI evolves as a leadership organisation membership will be optional and given PSNI's current status I cannot see too many signing up to the £300 fee. We will still be required to pay £400 for membership of the GPC. £700 will be too much for most pharmacists so an optional fee will be forgone by employers who pay most retention fees anyway.

I think a UK solution, option four on the PSNI list, is the most sensible, practical and cost-effective.

Written by a pharmacist practising in Northern Ireland

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C+D Clinical

Detecting infertility

A couple having problems conceiving may ask their pharmacist for advice. This article looks at the possible causes of both male and female infertility

Key points

- Many couples are subfertile but few are infertile.
- Several factors govern success, including ovulation, timing of intercourse, sperm quantity and quality, and physical barriers.
- Some 30 per cent of men are subfertile, and 2 per cent are infertile.
- The most important factor affecting a woman's fertility is age. By 40, a woman will only ovulate during half of her cycles.
- A semen analysis is often the first test.
- Most couples do not become pregnant immediately they start trying for a baby.
- A single cause is identified as the sole reason in a minority of patients.
- Couples trying for a baby should stop smoking and taking recreational drugs, and reduce drinking.
- Have regular sex, and use tests to pinpoint the most fertile time.
- Taking folic acid will reduce the risk of spina bifida.

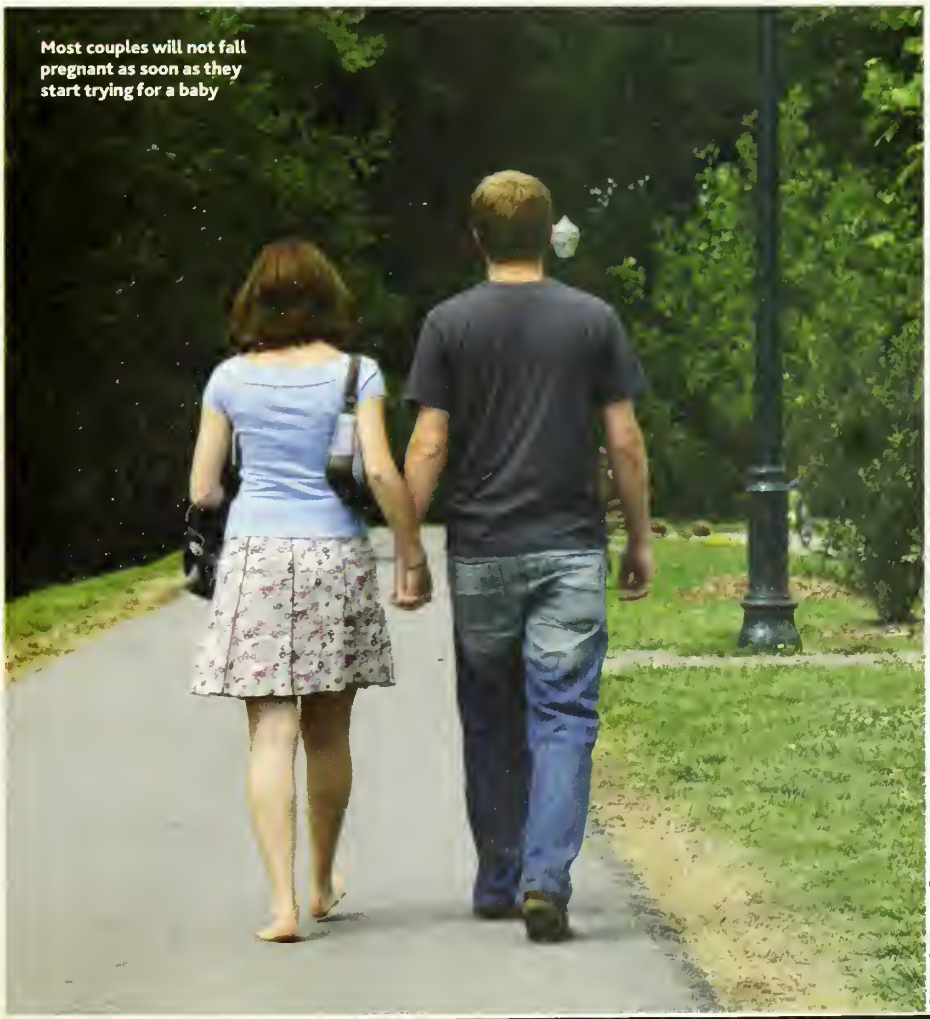
Reflect

Do you know which physiological factors affect fertility? Can you list five causes of male infertility? Do you know what investigations might be carried out on a couple who fail to conceive?

Plan

This article describes the main reasons for infertility in men and women, and what investigations might be carried out. It mentions advice pharmacists might give, together with useful websites for couples with fertility problems. The article is the first of two on assisted conception; part two, in next week's issue, will look at infertility treatments.

CPD This article can help in the following CPD competencies: G1a, C1f, C2a, C2b, C2e, C2f. See www.tinyurl.com/194zu



Most couples will not fall pregnant as soon as they start trying for a baby

Photo: Morguefile/Mary R Vogt

Asha Fowells

It's a quiet Saturday afternoon when you notice Mr and Mrs Fisher enter the pharmacy.

Rosie and her husband Phil are in their mid-30s and work long hours as IT consultants. They are fairly regular customers and ask your assistant if they can speak to you privately. You join them in the consulting room.

"We've been trying for children for a few months now, but nothing's happened," starts Rosie. "It seems a bit soon to trouble the GP, but we thought we'd ask you if there's anything we can do to improve our chances."

Phil continues: "I think we're also worried about the worst case scenario of one, or both, of us being infertile. It'd be good if we could learn something about what it might be and what tests we'd have to do if it gets that far."

Facts about infertility

Infertility is defined as the failure to conceive, despite the otherwise healthy couple having

regular intercourse without contraception. The term is subdivided into primary infertility – an inability to conceive at all, and secondary infertility – when conception proves impossible despite having had a successful pregnancy in the past, or if there have been one or more miscarriages or stillbirths.

Few couples are actually infertile. More commonly, couples are subfertile, meaning they can conceive with medical help. The term also applies to women who fall pregnant but subsequently miscarry. Figures vary, but it is thought that around a quarter of all couples will have problems becoming pregnant.

Contrary to popular opinion, most couples will not fall pregnant as soon as they decide to start trying for a baby. There are several physiological factors that govern success:

• **Ovulation** The balance of hormones must be correct for a woman to ovulate. The cycle starts with the release of follicle stimulating hormone (FSH) to stimulate the ovaries. In turn, this triggers the production of oestrogen to make the egg grow. Luteinising hormone (LH) then causes the egg to be released by the ovary (ovulation). Progesterone production steps up to prepare the uterus for a fertilised egg. If conception does not occur, progesterone levels drop, causing shedding of the uterine lining.

• **Timing of intercourse** Fertilisation will only take place if intercourse occurs around the time of ovulation. As ovulation occurs once in a menstrual cycle, there are only a few days per month when a woman is likely to fall pregnant. This window is created by the ability of the egg to live for up to 24 hours after ovulation, and the fact that healthy sperm can survive for up to three days in a woman's body.

• **Sperm quantity, motility and morphology** For fertilisation to occur, a man must produce sufficient quantities of motile (swimming) sperm. FSH and LH are involved in sperm production as well as in the female menstrual cycle.

• **Physical barriers** Obstacles such as a blocked Fallopian tube can prevent the sperm reaching the egg, stopping fertilisation.

Male fertility problems

Again, figures vary but estimates put the proportion of men who are subfertile at around 30 per cent, and those who are infertile at about 2 per cent. Male fertility problems have many causes:

• **Obstruction** A sperm-carrying tube can become blocked, the usual causes being groin surgery, trauma and infection (common culprits are chlamydia and gonorrhoea).

• **Testicular problems** Injury, infection, inflammation (also known as orchitis) and torsion (twisting of the testis) can cause testicular swelling or bleeding. This can lead to impaired blood supply and, in turn, failure to produce sperm.

• **Sperm disorders** Many things can affect sperm numbers, motility and morphology, including heat, excessive intercourse, alcohol and drug misuse, previous infection or illness, and fatigue.

• **Varicocele** This common condition, which is essentially a varicose testicular vein, causes the testis to be warmer than normal or have impaired blood supply, and fertility levels drop.

• **Erection and ejaculation problems** Erectile dysfunction and premature or failed ejaculation all impede successful intercourse, affecting the chance of conception.

• **Genetic disorders** Men with chromosome abnormalities may suffer from stunted testicular development or impaired sperm production.

• **Hormonal imbalance** Testosterone deficiency and hyperprolactinaemia both affect fertility.

• **Other conditions** Many diseases reduce fertility, ranging from nerve damage caused by diabetes, stroke or multiple sclerosis, to erectile problems as a result of hypertension.

• **Drugs** Medicines and recreational drugs can affect fertility. Common culprits include cytotoxic drugs (including methotrexate), digoxin, sulfasalazine, phenytoin, amiodarone, tobacco, cannabis, opiates, steroids and alcohol.

Problems due to the man or woman account for about 40 per cent of fertility problems each – and 20 per cent are due to joint problems

Female fertility problems

The most important factor affecting a woman's fertility is her age. Fertility begins to drop around the age of 25, and by 40 she will ovulate during just half her menstrual cycles. However, there are many other variables that influence fertility:

• **Ovulation problems** These usually occur because of a hormonal imbalance. The best known is polycystic ovarian syndrome (PCOS), in which LH production is too high and FSH levels too low, resulting in the ovary filling with cysts of immature follicles that cannot produce eggs. Other hormonal problems that can inhibit ovulation are hyperprolactinaemia and premature menopause.

• **Abnormal cervical mucus** Around ovulation, cervical mucus becomes thin and watery so sperm can easily swim through it. However, in some women the mucus remains thick or they do not produce enough.

• **Endometriosis** The build up of endometrial tissue outside the uterus can affect fertility in many ways. For example, overgrowth occurring elsewhere in the reproductive system may cause an obstruction or distortion, or trigger an unwanted immune response to the embryo.

• **Blocked Fallopian tubes** Sexually transmitted diseases, endometriosis, pelvic inflammatory disease and surgery may lead to scarring of the tube, preventing the egg's passage to the uterus.

• **Ovarian adhesions** Scarring of the ovaries can occur following an infection, surgery, endometriosis or pelvic inflammatory disease, and impede the release of eggs into the Fallopian tubes.

• **Uterine abnormalities** An embryo may have problems implanting in the lining of a uterus that is malpositioned or mis-shaped.

The most common example is fibroids.

• **Other conditions** Like men, women may experience reduced fertility because of another condition. Cancer, for example, may affect the reproductive organs directly because of the location of a tumour or indirectly because of treatment side effects. Other examples include diabetes and abdominal conditions, which can cause the entire abdominal cavity to become inflamed.

• **Weight** Body fat affects the release of gonadotrophin releasing hormone (GnRH), the trigger for both LH and FSH. Being underweight reduces GnRH production, causing ovulation to become irregular or even stop. Being overweight can cause excess insulin production, leading to irregular ovulation and contributing to the development of PCOS.

Investigations

The tests conducted as part of fertility investigations vary, but a semen analysis, ordered by the GP, is often the first because it is cheap, relatively non-intrusive and the results are quickly obtainable.

This is followed by chlamydia tests for both partners, blood tests for ovulation and rubella, and a cervical smear. Other examinations are likely to be conducted in a stepwise fashion and will require several hospital visits.

Couples should be counselled that a single factor is identified as the sole cause of infertility in fewer than a quarter of cases. This can be frustrating, especially as no cause may be found at all. Generally, men and women each account for about 40 per cent of fertility problems, and jointly for the remaining 20 per cent.

The most commonly performed fertility investigations are:

Semen analysis

The World Health Organization definition of a normal sperm count is:

• A minimum concentration of 20 million spermatozoa per ml.
• A minimum semen volume of 2ml.
• A minimum of 75 per cent live spermatozoa per sample.
• At least 30 per cent spermatozoa to be of normal shape and form.
• A minimum of 25 per cent spermatozoa should be swimming with rapid forward movement, and at least 50 per cent should be swimming forward, even if slowly.

Men may be asked to produce more than one sample, sometimes more than a week apart, because of the large variations that can occur.

Ovulation profile

Measurement of serum progesterone levels, ultrasound monitoring for follicular development, and testing of cervical mucus for quality, clarity and anti-spermatozoal antibodies.

Laparoscopy

This procedure may be conducted under general or local anaesthetic and enables examination of the outside of the uterus, Fallopian tubes and ovaries. It is particularly useful in detecting or ruling out tube disorders and endometriosis. Recovery usually takes a couple of days and complications are rare.

Hysterosalpingography (HSG)

X-ray detectable dye is injected into the uterus and Fallopian tubes to check whether there is any blockage or abnormality. The procedure can be painful and there is a risk of infection.

Hysteroscopy

A tube and scope is inserted into the uterus (via the vagina and cervix) and a gas or liquid passed through to separate the uterine walls. This allows inspection of the inside of the uterus and can detect tumours, fibroids, scarring and polyps. Associated risks include bleeding and infection.

Male hormone profile

Determination of LH and FSH levels is performed if measurement of testosterone has not gained insight into the problem. Depending on the results of this and the semen analysis, an ultrasound may be conducted to check whether there are any blockages in the tubes, or dye may be injected to visualise the tubes.

Back to the Fishers...

It is clear that you cannot give Rosie and Phil a definitive answer as to why they are taking longer than expected to fall pregnant, but they seem satisfied with the information you have provided. They say they are going to try for another couple of months before seeking advice from their GP, and ask if there is anything they can do to increase their chances of success. You advise the following lifestyle modifications:

• Stop smoking and using recreational drugs, and minimise alcohol consumption.
• Eat a healthy diet and take regular exercise.
• Avoid stress.
• Have regular sex, using ovulation tests to pinpoint the most fertile time of the month.
• For Rosie, taking folic acid will reduce the risk of spina bifida and similar abnormalities if she does fall pregnant.

A further article, to be published on August 11, will cover infertility treatments.

For more information:

• The Human Fertilisation and Embryology Authority – www.hfea.gov.uk
• Infertility Network UK – www.infertilitynetworkuk.com

Asha Fowells is clinical and CPD editor, C+D.

Continuing Professional Development CPD

Act

• Revise how ovulation tests work and make sure your assistants can explain how they are used.
• Revise the hormonal regulation of the menstrual cycle (eg C+D, January 19, 2002, p25). See also http://users.rcn.com/jkimball.ma.ultranet/BiologyPages/S/SexHormones.html or http://biology.clc.uc.edu/courses/bio105/sexual.htm
• Do you have leaflets to hand out advising on fertility? Make a note of the websites mentioned in the article so you can refer couples to them for information. The HFEA site (www.hfea.gov.uk) lists clinics and has links to further sources of help.
• The article recommends eating a healthy diet to improve the chances of pregnancy. Are there any vitamin or mineral deficiencies that might contribute to infertility? Research the evidence to see if there are any specific nutrients you might recommend.
• Find out more about how female hormones influence male fertility.
• Look at www.labtestsonline.org.uk to discover more about the tests that might be carried out on a couple with fertility problems.

Evaluate

Do you now feel more able to answer questions about fertility problems and where to refer couples for further information (as well as to the GP)? How would you explain to a man that failure to conceive might not necessarily mean that something is wrong with his partner?

A Practical Approach...

Nilesh Patel has called an emergency meeting of six local pharmacy contractors one evening after hours.

"We all know why we're here," he says, "but I'll repeat it for the record. A company is intending to apply to the PCT for a contract to open a '100-hour' pharmacy in this area. The site will take dispensing business away from all of us. I've convened this meeting so we can take action to defend our businesses. David Spencer of Update Pharmacy and I have been doing some research, and we've come up with an idea. Would you like to tell us about it, David?"

"OK," says David. "I think we could block this plan by setting up an after hours service ourselves."

"But how could that stop a '100-hour' pharmacy opening?" asks Meir Godol.

"By doing it as an LPS," replies David. "We would put forward a proposal to provide a service, on a rota basis, matching 100 hours per week opening, including on Sundays and bank holidays."

"Who would pay for it?" asks Colleen Lashman.

David replies: "The PCT, if they agreed to the service."

"Couldn't the PCT just turn us down out of hand?" says David Walker.

"Luckily, no, as it's an 'open' PCT," Nilesh replies.

"It just sounds too easy to me. There must be a drawback somewhere," Martin Bond says.

David replies: "Nilesh and I believe there is, but we think we should go ahead anyway."

Questions

1. What are the essential elements of an LPS?
2. How can an LPS stop a '100-hour' pharmacy from opening?
3. How is an LPS paid for?
4. What is the significance of the PCT being 'open'?
5. What might be the main drawback to this LPS proposal?

→

CPD

This article can help in the following CPD competencies: G1j, G1h, G4f, C5c, C5e. See www.tinyurl.com/194zu

Cannabis raises psychotic illness risk in later life

Young people should be warned that using cannabis increases their risk of psychotic illness later in life by more than 40 per cent, a study published in The Lancet has concluded.

A meta-analysis by Dr Theresa Moore of the University of Bristol and Dr Stanley Zammit of Cardiff University found that individuals who had used cannabis were 41 per cent more likely to have psychosis than those who had not used the drug. They also reported that the heaviest cannabis users were more than twice as likely to have a psychotic outcome.

The authors of an accompanying comment argued that there was a need to warn the public of the dangers of cannabis, and to establish a treatment for young frequent cannabis users.

Lancet 2007; 370: 319–28, Lancet 2007; 370: 293–4.

Experts warn GPs to curb antibiotic prescribing

Experts have again called on GPs to reduce antibiotic prescribing because of the danger of resistance.

The call came from the authors of a study published this week on BMJ Online First that showed prescribing amoxicillin to a child in general practice doubles the risk of beta-lactam resistant bacteria two weeks later. The authors said current levels of antibiotic prescribing could be enough to sustain resistance.

Last week a report published by the Journal of Antimicrobial Chemotherapy warned that many GPs were risking adding to resistance by continuing to prescribe antibiotics for 80 per cent of patients who consulted with upper respiratory tract infections. Led by Professor David Mant of the University of Oxford Department of Primary Healthcare, the authors of the new study concluded that substantial and sustained changes in prescribing were required. www.bmj.com

A Practical Approach... this week's answers

1. A local pharmaceutical service (LPS) is a local contract between the PCT and a pharmacy contractor or consortium of contractors, and is a means of providing community pharmacy services outside the NHS contract. A proposal must show a clear benefit to patients, the PCT and the contractor(s). It must involve the dispensing of prescriptions, which are paid for in the usual way.
2. Pharmacies opening for 100 hours per week must normally be granted an NHS contract automatically, and are exempted from the test of necessity or desirability. However, PCTs cannot grant such applications if there is, or will be, an LPS in the neighbourhood.
3. By transfer of funding from the global sum for pharmaceutical services to the PCT. It is also possible to obtain from the PCT payment to cover the cost of making an application.
4. The PCT is open to proposals from contractors for LPS. 'Closed' PCTs put forward their own proposals for LPS and do not accept them from contractors.
5. The PCT would have to find funding for this proposal, while allowing a 100-hour per week pharmacy to open would cost nothing. The consortium would have to show that its proposal is cost-effective.

New Brochlor ointment, containing chloramphenicol, is for when you need to give eye trouble a real wallop. It's ideal for overnight use, children and the elderly and doesn't need to be refrigerated. So while Brolene is still very tasty at sorting minor eye infections, including bacterial conjunctivitis, blepharitis and eyelid infections, there's now "Big Bruv" Brochlor, which contains chloramphenicol, for when you need to hit acute bacterial conjunctivitis hard. By choosing Brolene for minor problems and saving Brochlor for the tougher stuff, you will have the option to take appropriate action. So if you have an eye infection causing trouble, let the Bro's knock it out.

If you would like more information about Brochlor or Brolene, and copies of training materials and point of sale items, contact your local Laser Healthcare Pharmacy Business Manager or call sanofi-aventis on **01483 505515**.

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Date of preparation: June 2007
BRO-06/034

New-look Panda packaging

Liquorice brand Panda has been given a new look with redesigned packaging across the range. To aid consumer selection, on-pack flashes give messages such as 'Fat free' and 'All natural ingredients'.

The brand claims to be growing at more than 30 per cent year on year. Lisa Gawthorne, Panda marketing manager, comments: "Ingredients integrity is the core to Panda's continued success. There are so many great things to shout about with the Panda brand, it's about time we made some more noise on pack."

The Panda range includes several flavours across a single bar, multipack and bag formats. Shelf wobblers are available.

Product info:
Bio-Stat
Tel: 0161 419 6307

Products in brief

Senokot's on TV

Television advertising for Senokot Dual Relief, the RB constipation treatment launched earlier this year, has just begun. The national campaign runs until early September. Reckitt Benckiser
Tel: 01482 326151

More vet meds coming

The Veterinary Products Committee has recommended the declassification of a range of cat flea products from POM-V to NFA-VPS. The affected products include Advantage, Fleegard and Top Drop variants from Bayer Animal Health and Merial's Frontline Combo Spot on Cat and Frontline Spray.

Add some texture

Dirty Clean Texturising Paste has been added to the Studio Line range from L'Oréal Paris. It can be applied to dry or damp hair to give the "morning-after rough texturised effect" says L'Oréal. Price: £4.29/75ml, Pip code: 328-4866, L'Oréal Group UK
Tel: 0161 655 1400

Brush up on brush heads

Oral-B is launching an in-store initiative later this month aiming to help consumers choose the right brush head. The company has standardised its range of replacement heads, introducing easy to read benefits and colour coding. It recommends using a promotional stand and shelf enhancer to merchandise the range. Oral-B Labs
Tel: 01932 896000

Kleenex reshapes boxes

Kleenex is targeting consumers with an interest in interior design with its latest launch, Ovals. Four designs of the oval-shaped boxes are available, positioned as colour co-ordinated accessories for the home. Price: £1.99/64 tissues. Kimberly-Clark, tel: 01732 594000

It's a snore point

Anti-snoring product Asonor has been launched by Pharma-Export.

The nose drops contain sodium chloride, glycerol and polysorbate with potassium sorbate as preservative. Users should apply three or four pumps to each nostril at bedtime and the liquid should be felt in the throat. The drops lubricate and soften the mucous membrane and tighten the musculature in the throat, says the company.

In clinical trials, 65 per cent of snorers said they were 'satisfied' with Asonor. More than 80 per cent of users say they are less tired during the day, claims Pharma-Export.

Price: £9.95/30ml
Pip code: 329-8643
Product info:
Pharma-Export
Tel: 0208 582 0155
www.asonor.com

Carbon impact on display

Boots is introducing carbon reduction labels to point of sale materials as the Carbon Trust's trial of the labelling system, designed to help consumers cut their carbon footprint, moves forward.

The information will show the carbon footprint of a range of Botanics shampoos and will be seen in more than 250 stores nationwide.

The carbon footprint of Botanics shampoos has been reduced by 20 per cent, says Boots.

Product info:
www.carbon-label.co.uk

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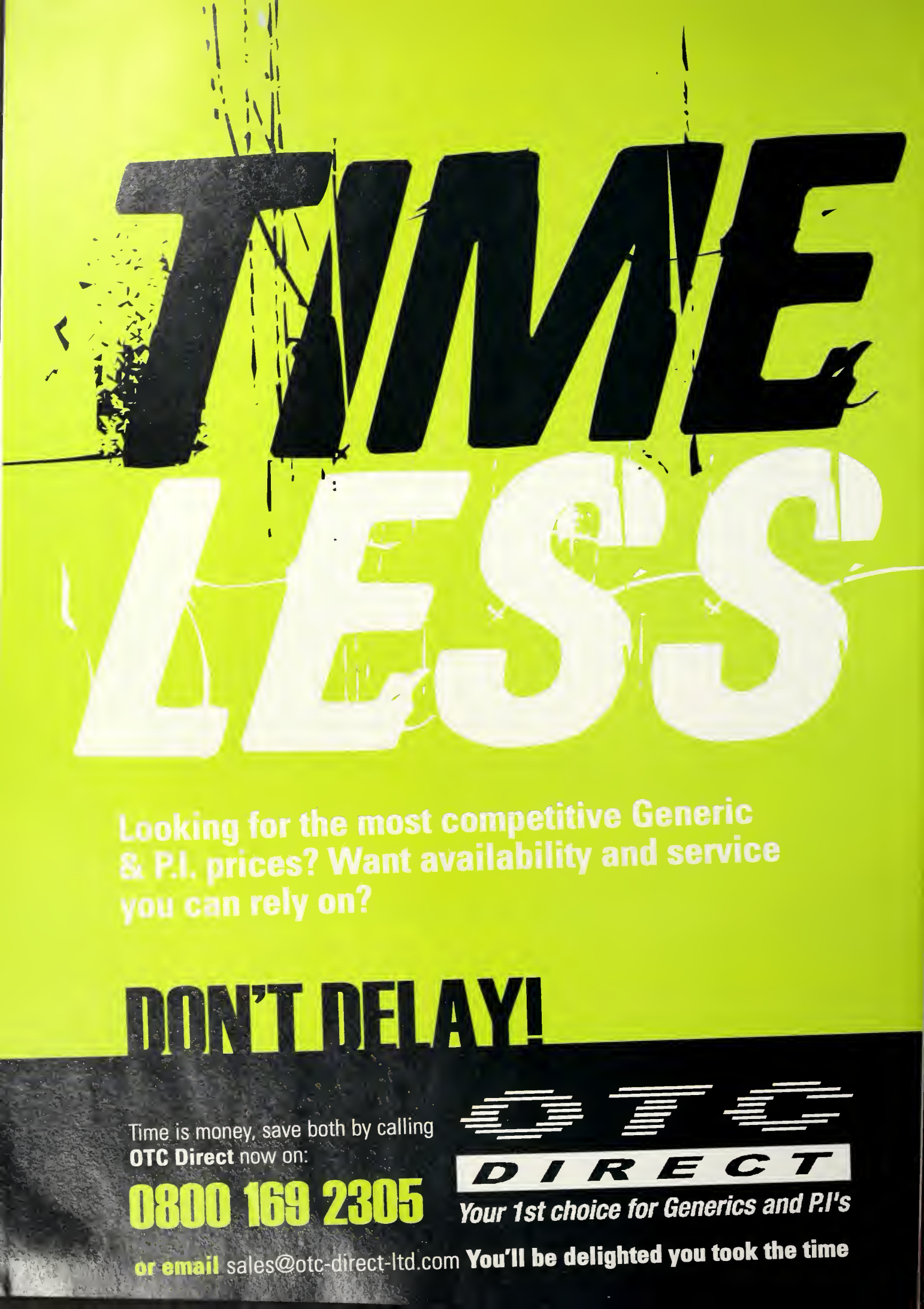
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Sula seeks sugar-free sweet success

The Sula brand of sugar-free sweets has been updated with new flavours and recipes, modern packaging and a more competitive price position.

Joining the line-up, a premium-quality range of toffees has been launched. Four flavours in 80g bags are available.

The new range of five Sula Natura products comprises strawberry cream, vanilla mint, cappuccino cream, caramel cream and fruit mix sweets in 80g bags and 42g boxes.

Supporting the brand, national consumer sampling aiming to reach more than a million people is running, backed up by regional advertising.

The Sula roadshow is visiting 40 events including the BBC Good Food Show, the Vitality Show, festivals and sporting fixtures. A 'buy-one-get-one-free' promotion is running on the flip-top boxes while bagged variants will offer 33 per cent extra free from September to November. Above-the-line advertising is planned for 2008.

Price: Natura 99p/80g, 59-75p/42g; Toffees £1.09/80g
Petty, Wood & Co Ltd
Tel: 01264 345500

Vegenat offers more taste variations

The Vegenat range of instant textured modified meals has been extended with the introduction of some new flavours.

Vegenat-Med products are suitable for dysphagic patients, the elderly, cancer patients and those with neurological conditions such as Alzheimer's disease. New flavours include savoury and sweet options.

The products are high in protein and energy, low in sodium and lactose, gluten-free and suitable as sole nourishment.

All are ACBS approved. Vegenat-3 is a new range of fruit purees comprising apple, pear and apple and apricot variants, available OTC.

Product info:
UDG
Tel: 01773 510123
www.vegenat.com

New spray from Salts

A spray format of Salts' WipeAway product to aid removal of the residue left by an ostomy pouch is newly available.

It should be sprayed on and around the adhesive when removing the pouch or flange and then onto the skin around the stoma to remove any adhesive residue. The spray soothes the skin and leaves a hint of lavender, says Salts.

Pip code: 329-0236
Salts Healthcare
Tel: 0121 333 2000

Products advertised on TV next week

Clearblue

Bepanthen: All areas
Bio-Oil: All areas, except GMTV
Canesten: All areas
Cuticura: All areas, except GMTV
Deep Freeze Patch: All areas, except GMTV, C4, Five
DulcoEase: GMTV, Sat, Five
Frontline: GMTV, Sat, Five
Jungle Formula: GMTV
Just For Men: All areas
Magicool: All areas, except Sat
Odoreaters: All areas
Seabond: All areas
Senokot Dual Relief: All areas
Vagisil: All areas
Wartner: G,Y,C,M,LWT,GMTV,Sat
PharmaSite for next week: Oilatum – windows, **Oilatum –** in-store, **Oilatum -** dispensary
Pharmacy channel: Piriton, Clearly Herbal

A-Anglia, B-Border, C-Central, C4-Channel 4, five-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

Forest unveils competitive streak

Five Hamley's teddy bears are up for grabs to independent pharmacy customers, courtesy of Forest Laboratories. The company is running the prize draw to celebrate Sudocrem's 30th birthday.

Alongside, the Infacol Probiotic Drops brand is offering pharmacy staff the chance to win £50 worth of Marks & Spencers vouchers. For both competitions, entry leaflets are being distributed to independent pharmacies by Forest reps. The closing date for entries is September 30.

Product info:
Forest Laboratories Europe
Tel: 01322 550550

Learning by numbers

Can pharmacy learn from Tesco's success? Tracy West believes it can, starting with the ever popular Clubcard

Nobody can dispute the power of Tesco. According to the latest TNS figures, it currently holds a 31.6 per cent share of the UK grocery market. In the UK it has a total of 1,500 stores, however it's not content with just its home market and is fast expanding overseas. Indeed later this year it is entering the difficult US market with its new Fresh & Easy fascia. Tesco's successes are really too many to mention but chief among them is the Clubcard – which consumers love because it gives them money off their groceries, and which Tesco loves because it gives it the sort of consumer data that money can't buy.

Obviously an independent pharmacy would never be able to replicate the enormity of Tesco's success but there are some valuable lessons that can be learned, which could give them a small share of that success. In this series we take a look at four of Tesco's major successes: Clubcard, diversification, clubs and home delivery; and see what pharmacies can learn from the grocery giant.

Tesco Clubcard

Lots of retailers have launched loyalty cards and many have failed but Tesco is different. It's famous for its Every Little Helps slogan and the one thing that's helped the superstore chain stay ahead of its competitors more than anything else is its Clubcard. So what is it about its card that's made it such a success and are there lessons for the pharmacy sector?

First off, Clubcard needs to be put into perspective – it is one of the UK's most popular loyalty card schemes with more than 13 million active members. There have even been two books written about the Clubcard – Scoring Points: How Tesco is Winning Customer Loyalty, and Scoring Points: How Tesco Continues to Win Customer Loyalty.

The loyalty card was launched in 1995 in conjunction with relevance marketing company Dunnhumby and Tesco now owns a majority stake in the firm. When Clubcard was first launched it was viewed as a huge risk, however over the years it has been copied by other supermarket chains.

"Clubcard forms a key part of Tesco's corporate philosophy, which is to create better value for customers in order to earn their lifetime loyalty," explains Corinne Millar, UK retail analyst at Planet Retail.

Clubcards are free to customers – they simply fill in a few details on a form and start accumulating points. The card is then swiped at the till each time a purchase is made. For every £1 spent, customers receive one point, which is worth 1p. Points are accumulated and every 12 to 13 weeks members receive money-off coupons and offers tailored specifically to them. Apparently there are over 80,000 different combinations of offers with each

Clubcard mailing, to ensure that customers receive the one that is most suited to them. More than £320 million-worth of vouchers have been sent to customers in the past year.

Gavin Rothwell, senior business analyst at the Institute of Grocery Distribution (IGD), comments: "Clubcard has been a crucial tool for Tesco over recent years. Indeed, a fundamental principle of Tesco is to follow the customer. Clubcard plays a pivotal role in facilitating this.

"The scheme is firmly established as a key element of Tesco's marketing strategy and fulfils a variety of functions for the retailer. Firstly, customers receive a direct benefit from the scheme through the Clubcard point rewards they gain with purchase. Tesco also has the ability to flex these rewards where it suits, for instance it is currently offering triple points for a number of online purchases.

> "The data provides a unique insight into the shopping patterns of British consumers"

"Secondly, the scheme drives loyalty among customers through the rewards. And thirdly, it provides valuable customer purchasing pattern information. This then feeds back into Tesco's marketing and product offer development."

Purchasing data is collected from the cards and put through a very sophisticated software system which helps to build a socio-economic profile of trading areas and customers. Patterns are identified such as who visited a store during a week, how often and what part of the store they

bought from. Says Mrs Millar: "The card is used by Tesco to help understand its customers, using purchasing data to create a picture of the kind of person each customer is."

People are segmented into different lifestyle groups dependent on the products they purchase. Groups include 'convenience' which takes in the cash rich, time poor; 'price-sensitive' – those on a budget; finer foods – those who go for organic and Finest goods; and mainstream – those who buy major brands and lots of products for children.

Mrs Millar says that as Tesco has such a large penetration across the country, the data provides a unique insight into the shopping patterns of British consumers. "It enables the company to make informed strategic decisions and has prompted its move into new markets such as convenience, online, mobile phones and pet insurance." Once Dunnhumby has processed the data from the clubcards it publishes a small sample which is sold on to suppliers. This enables them to see how well products and promotions are performing in different locations. "Using this data is becoming increasingly important to suppliers when dealing with Tesco," says Mrs Millar. "With this additional insight, manufacturers can monitor promotions and are then able to communicate directly with customers via targeted offers in Clubcard mailings or coupons at the till."

> "Tesco has invested millions in Clubcard, however it won't disclose any costs"

The IGD's Mr Rothwell says Tesco has worked with manufacturers such as Cafédirect and P&G to mail product samples in conjunction with Clubcard. "The card has also been used to encourage lapsed customers to visit at key times – such as in the run-up to Christmas – and therefore is a key customer retention tool," he says. Indeed, lapsed customers get sent generous money-off vouchers that are not tied to specific goods. These tend to be along the lines of 'Spend £70 and get £7 off'.

Tesco states that in order to protect consumer privacy no third party has access to individual names and addresses. This is important to consumers, some of whom are worried about data being shared. There have been newspaper articles and TV programmes with scare stories about the amount of information Tesco has about its customers but so far those customers seem happy to reap the rewards of the Clubcard. There is a Clubcard Customer Charter which gives members reassurance that their details are safe with Tesco and also gives them the chance to opt out of receiving mailings and offers. However, it seems most shoppers are keen to receive the money-off deals.

Many shoppers use their Clubcard vouchers directly in store to get money off their shopping, however the vouchers are much

more valuable when used in Clubcard Deals. And that's because if you exchange your vouchers for deals you get four times their value. Deals include airmiles; days out to places like Legoland and Madame Tussauds; RAC breakdown cover; travel on Eurotunnel; meals in Café Rouge restaurants; breaks at hotels; and DVD rentals at Blockbuster.

Deals can also now be used for sessions at Allen Carr's EasyWay to Stop Smoking Clinics and to fund Open University courses.

Tesco has even used Clubcard to jump on the green bandwagon and now offers green points. TV advertising featuring Ronnie Corbett and Alan Whicker using items other than carrier bags to transport their shopping home, was used to launch the green points.

Tesco's stated aim was to cut the number of bags it gives out by 25 per cent in two years. In addition, every Clubcard customer was given a voucher entitling them to a free reusable Bag for Life. By February, Tesco was saying that its reusable bag scheme had saved 300 million carrier bags.

The Clubcard Green campaign was strengthened this year when Tesco ran an eight-week campaign offering consumers double points on green and organic ranges. Green points can also be earned for recycling mobile phones and inkjet printer cartridges.

Obviously Tesco has invested millions in Clubcard, however it won't disclose any costs.

Says Mr Rothwell: "Replicating Clubcard, or developing a comparable scheme, would be a costly operation and would only work for an operation with sufficient scale. However, the principle of offering rewards in exchange for customer loyalty has broader application. Information gained from this could then feed into product offer development. Schemes involving several different complementary retailers may be easier to implement for smaller operators." Mrs Millar puts it succinctly: "It's all about understanding your customers, predicting their needs and tying it in with promotions."

Tracy West is a freelance journalist who has written for the grocery trade press for 22 years

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Mrs. Debbie Blackwell
Deputy HR Manager
PHOENIX Healthcare Distribution Ltd.
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WA7 3DJ

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To advertise call Chris on 020 7921 8123

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3001

Shopfitting

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From: **Hawkeye on the web**

Date: **Sat 4.08.07**

Subject: **Flood aftermath**

By 6pm, all manner of debris was floating around, with the water threatening to ruin irreplaceable paper notes and computer equipment

Standing in his flood-soaked pharmacy searching for medicines, Mike Hewitson watches as a plastic turtle floats by. Less than an hour before, the pharmacy was dry and full of patients. Now, there is no power, it is under two feet of water and it's cold.

From upstairs in the safe area, there is the sound of a baby crying. It is waiting with its mother to be rescued by the police along with two other patients and the staff from the pharmacy and adjoining surgery who are stranded by the water.

Mike, the pharmacist at Saintbridge Pharmacy in Gloucester, is looking for a pMDI and spacer to treat the elderly COPD patient upstairs who is becoming increasingly anxious at the situation.

The floods literally came in a flash. At 3:30pm on Friday July 20 they were warned that the normally sedate brook nearby could burst its banks. Despite Mike's frantic efforts to secure the premises with sandbags, there was no stopping the flow. At 4:05pm water began streaming through the door and patients were ushered to safety as the levels began to rise. By 6pm, all manner of debris was floating around, with the water threatening to ruin irreplaceable paper notes and computer equipment.

"It was a very surreal experience as we had everything from children's toys to acupuncture equipment floating in the water," explains Mike.

You can get a clear picture of the chaos at Mike's Facebook page at tinyurl.com/34kytd. Elsewhere online there are further stories of affected pharmacies. The Times reports that in Slad Road, Stroud, Lloydspharmacy was inundated by black mud above the height of its cabinets. It also reports that waters rose so fast at the local Co-op supermarket that staff had to break through a fence to escape (tinyurl.com/27chez).

More pictures of the devastation from the floods of middle England can be seen on the BBC Gloucester website at tinyurl.com/3daynk.

Like Wicker Pharmacy in Sheffield, which was drenched in June's monsoons (tinyurl.com/2fj3la), Mike and his team at Saintbridge were determined not to let the freak weather impede their service to patients. An almost normal service was restored the following Monday and the pharmacy played a pivotal role in ensuring that people affected by the floods didn't go without any essential medication. It provided a prescription triage system since the entire supply of FP10 paper had been lost, and gave health advice regarding the sodium content of some bottled waters. On Wednesday Saintbridge received a visit from health minister Ben Bradshaw who surveyed the damage and recovery operations.

Mike estimates he has lost over £12,000 in damaged stock and the whole pharmacy now requires a refit less than three years after its last. Despite all this, he has been able to draw positives.

"I think the response of my staff has been tremendous. It has also demonstrated how the pharmacy has been at the centre of the community and has aided patients to get back to normality and has even shown GPs what an asset the pharmacy can be."

Email thawkins@cmpmedica.com

... what's new on the C+D website ...

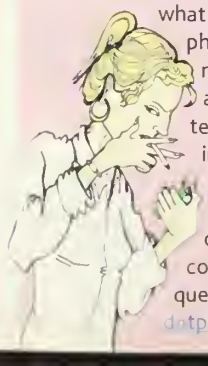
Free email news

Get the top pharmacy stories before they appear in print by signing up to C+D's free email newsletter service at dotpharmacy.com/newsbulletins

If you sign up during August you will be entered into a free prize draw to win £200 in **John Lewis vouchers**

What do you really think of your staff?

Support staff are destined to play an increasingly important role in pharmacy healthcare provision but what do pharmacists really think? Is a good technician worth their weight in gold? Are there enough to go round?



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dotpharmacy.com/staffsurvey

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2 Judge issues reprimand over 'smutty' weblinks
3 Celebrations in Camden over 100-hour dispute
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Send your entry to: Pharmacy Travel, CMP Information, Riverbank House, Angel Lane, Tonbridge, Kent TN9 1SE Incomplete entries will not qualify for the prize draw/holiday discount voucher

Rules **1** This competition is open to any pharmacist or permanent member of staff who works at an address which receives either *C+D* or Pharmacy Today **2.**Competitors may enter through *C+D* or Pharmacy Today, but may only submit one entry. Double entry will disqualify both entries **3** Entries must be on an original coupon from *C+D* or Pharmacy Today, and to be eligible for the prize entrants must correctly answer the question on the coupon **4.**The prize offered will be as stated. No alternative holidays or cash prizes will be offered **5** Names of winners will be published in *C+D* and Pharmacy Today **6** In any dispute, the decision of CMP Information Pharmacy Group's publishing director will be final and no correspondence will be entered into **7.**Employees of CMP Information Ltd, Affinity Travel Services and trading divisions and their immediate families are forbidden to enter **8** No purchase is necessary to participate **9.**The closing date for this month's competition is as printed on the entry coupon.


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